PROVIDER NAME:

WAIVER OF FULL OR REDUCED CONSUMER FEE AUTHORIZATION FORM

□ **New** □ **Extension**

Consumer Name: _____ **Consumer SSN:** _____

Date of Admission: _____ **Type of Service:** _____

Amount of Full Waiver: _____

All waivers must be accompanied by income eligibility documentation

INABILITY TO PAY JUSTIFICATION & DOCUMENTATION: Below check all those that apply:

□ **Financial Hardship**

□ **Homelessness** – without permanent address, without income, no disability income & no other income

□ **Student Assistance Assessment**

□ **Released from Jail** – from date of release from jail, a one-time **30 day** waiver of fees if needed due to financial stresses.
Date of Release: _____

□ **No Other income**

□ **Medicaid Spend-down** – as per the Insurance Benefit Policy

□ **Adolescents** – in addition to the above, Lack of Parental Involvement – refusal to pay

□ **Adolescents** – Lack of Parental Involvement – no parental signature/permission to bill insurance.

The above referenced client is eligible to have a fee waiver relative to his/her indigent status and his/her current inability to pay for the above services.

_____ _____

Program Director's Signature **Date**

_____ _____

Consumer's Signature **Date**

Begin Date _____ Expiration Date_____

Waiver Extension _____ Expiration Date_____

Fee Waiver must be filed in consumer's file.